

General Well-Being in Adult Black Males With Chronic Illness

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Abstract

As individuals age, they witness a decline in physical health and functional capacities. The presence of one or more chronic illnesses challenges their quality of life and general well-being, thus, impacting their abilities to function physically, psychologically, and socially. We investigated reports of general well-being in older Black males with chronic illness(es) in a study of $N = 145$ participants, aged 35 to 63, and identified as Black/African American male. Participants responded to items assessing general well-being; ethnic identity; self-esteem; active coping; the presence of chronic illness(es); and additional demographic, social and ecological characteristics. Analyses of responses indicated that marital status ($\beta = -.17, p < .05$), ethnic identity ($\beta = -.34, p = .00$), self-esteem ($\beta = .22, p = .03$) are significant determinants of general well-being in Black males with chronic illness(es). Data further showed active coping ($\beta = -.41, p = .09$) to be negatively correlated with well-being. We discuss the implications of results for the understanding of health outcomes among this marginalized population.

Keywords

general well-being, chronic illness, active coping, ethnic identity, self-esteem

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In recent years, the disparity between the health and well-being of Black males and other ethnic and gender groups continues to widen (Zack, 2013). For example, Black males have significantly shorter life expectancies and show a steeper decline in health as they age compared with all other racial groups and compared with Black women, who are expected to outlive Black males by 5 years (Pollard & Scommegna, 2013). In a national health interview survey conducted in 2016 by the Centers for Disease Control and Prevention in collaboration with the U.S. Department of Health and Human Services and the National Center for Health Statistics, 12.5% of the surveyed non-Latino African American males rated their health as poor to fair health, compared with 7.7% for White American males.

Current research shows that the presence of chronic illnesses in Black males is an important factor contributing to the mortality rates in Black males (e.g., Leung, Pollack, Colditz, & Chang, 2015; Siegel, Miller, & Jemal, 2016). Black males in the United States disproportionately suffer from chronic illness, have poorer prognoses, and are diagnosed later compared with other ethnic groups and genders (Aldwin, Igarashi, Gilmer, & Levenson, 2017; Weir, Thompson, Soman, Möller, & Leadbetter, 2015). Also, the presence of chronic illnesses in Black males add to inform the perception of their health and well-being because the presence of chronic illness

can significantly influence the ability to perform activities of daily living in older adults (Beard et al., 2016).

John Henryism and Black Males

“John Henryism” is a strong behavioral predisposition to cope actively with psychosocial and environmental stressors (James, 1994). This behavioral predisposition is modeled after the legend of John Henry, the “steel-driving man,” who was widely known among late 19th-century railroad and tunnel workers for the remarkable physical strength and endurance displayed in his work (James, 1993; B. Williams, 1983). According to the folklore, John Henry beat a mechanical steam drill in a famous “steel-driving” contest pitting “man against machine.” Although John Henry emerged the victor, he dropped dead from complete physical and mental exhaustion moments after the contest ended (B. Williams, 1983).

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The “John Henryism” hypothesis evolved from active coping and is particularly concerned with explaining the high coping efforts of many African Americans in high-stress environments. High active coping effort increases heart rate and blood pressure and can cause chronic conditions (e.g., cardiovascular disease and hypertension) over time. According to Folkman (1984), active coping is defined as thoughts and behaviors that people use to manage internal and external demands that are appraised as stressful. Recent literature suggests that John Henryism is most salient among African American men as a result of the racial discrimination and hardship they have had to overcome (Bronder, Speight, Witherspoon, & Thomas, 2014). Furthermore, researchers have found this behavioral disposition especially common in men when dealing with the presence of health-related stressors (Aspinwall & Taylor, 1997; Harburg et al., 1973; James, LaCroix, Kleinaum, & Strogatz, 1984; James, Strogatz, Wing, & Ramsey, 1987; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000).

Social Identity

In addition to explaining the extent to which active coping influences positive or negative outcomes, an individual's social identity can influence psychological outcomes. According to Tajfel (1972), social identity is the “knowledge that [we] belong to certain social groups together with some emotional and value significance to [us] of this group membership” (p. 292). Haslam and colleagues (2009) posited that because individuals tend to understand and respond to the social structural conditions in which they find themselves, as well as define their sense of self according to the groups they belong, social identity can be linked to health outcomes. For example, social identity can determine what a group considers as a normative healthy behavior to engage in (Atakere & Baker, 2016). It has also been linked to processes that influence general well-being (Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005; Wegge, Van Dick, Fisher, Wecking, & Moltzen, 2006).

Factors defining identity can be associated with self-esteem. The link between identity and self-esteem provides a more cohesive framework for understanding health behaviors and outcomes and predictive well-being among older Black males. Social identity theory (Tajfel & Turner, 1986) proposes that group members discriminate in favor of their in-group to establish a positive social identity and self-esteem. Furthermore, social identity theory helps explain how social identities can be associated with positive or negative health outcomes by understanding how people understand and respond to the social contexts they find themselves (Haslam, Jetten, Postmes, & Haslam, 2009). These effects may buffer well-being when it is threatened, or it may help individuals of marginalized groups to cope with the negative consequences associated with their group membership

(Haslam et al., 2009). For example, research found that higher ethnic identity—identification with one's ethnic or racial group—was associated with higher self-esteem for African Americans and other ethnic minority groups (Goodstein & Ponterotto, 1997; Martinez & Dukes, 1997). More specifically, research showed that group racial identification and the meaning one places on being a member of that social group protect African Americans from negative psychological consequences associated with negative experiences (e.g., perceived discrimination; Branscombe, Schmitt, & Harvey, 1999; Phinney, 1992; Sellers & Shelton, 2003).

Despite the extensive literature on chronic illness and general well-being, there is little or no literature focusing on general well-being in older Black males with chronic illnesses. This is a significant gap because aging Black males are at higher risk of encountering complexities of well-being given their daily-lived experiences as Black males (Baker et al., 2017; Jenkins, 2015/2016). Thus, the present research aims to better understand general well-being of older Black men with chronic illness. To contribute to our understanding of this population, the current study aimed to determine the significance demographic (marital status, education), social (ethnic identity, self-esteem), and psychological characteristics (active coping) have on general well-being among Black men. Determining the influence identified factors have on general well-being, beyond that of clinical and health indicators, is a strength of this study.

Method

Participants and Procedure

This study included a sample of males ($N = 145$) who self-identified as Black/African American, aged 35 to 63 years and were able to read and understand English and provide consent for study participation. We published a Qualtrics survey link on Amazon's Mechanical Turk (MTurk) website—a crowdsourcing Internet marketplace that allows community-based individuals to participate in academic research on Amazon's platform for money. The published link was tailored to target Black/African American males, aged 30 years and above, who live within the United States. Attention checks were put in place to ensure that participants paid attention to the survey. In addition, we utilized location validation to ensure that only males in the United States completed the survey and the IP address blocker to prevent participants from submitting more than one response to the survey. The participants responded to measures assessing general well-being, ethnic identity, self-esteem, active coping, the presence of chronic illness(es), and additional demographic, social, and ecological characteristics. The online survey was designed to last approximately 30 min. The

data were collected within 12 hours, and respondents received US\$1.00 for participating in the study. The university's Institutional Review Board approved this investigation.

Measures

Primary outcome

General well-being. The General Wellbeing (GWB) scale (Dupuy, 1984) consists of 18 items indicating subjective feelings of psychological well-being and distress. All of the items utilize the past month as the time frame of interest. Participants responded to the first 14 questions (e.g., Have you been in control of your behavior, thoughts, emotions, or feelings?) on a 6-point (1 = "not at all" to 6 = "very good") rating scale. The remaining four items (e.g., How concerned or worried about your health have you been?) were measured on a 1 to 10 rating scale, that is, anchored by adjectives 1 ("not at all") to 10 ("very good"). Because some items are reverse scored, 14 was subtracted from the total score, yielding a total possible range of scores from 0 to 110. Low scores represent greater distress. The scale demonstrated acceptable reliability ($\alpha = .78$).

Study Covariates

Social variables

Ethnic identity. Ethnic identity was assessed using the Multi-group Ethnic Identity Measure–Revised (MEIM) measure (Phinney & Ong, 2007). The MEIM is a six item questionnaire comprised of two subscales: exploration (seeking out information about their own identity) and commitment (the extent to which individuals feel attached to their ethnic group). Response choices ranged on a scale from 1 ("strongly disagree") to 5 ("strongly agree"), with higher scores indicating stronger ethnic identification ($\alpha = .77$).

Self-esteem. Self-esteem was measured using the Rosenberg's Self-Esteem scale (RSE; Rosenberg, 1965). This 10-item instrument is designed to measure global self-worth by assessing feelings about the self. Examples of the items on the instrument are: "I have a positive attitude toward myself"; and "I wish I could have more respect for myself." Participants rated themselves using a 5-point Likert-type scale ranging from strongly disagree to strongly agree, with high scores indicating higher self-esteem ($\alpha = .86$).

Psychological variable

Active coping. Active coping was measured with the John Henryism Active Coping Scale (James et al., 1987). This 12-item scale measures the behavioral predisposition to cope actively with difficult psychosocial stressors and barriers. The scale consists of three themes: a commitment to hard work, a determination to

achieve one's goals, and efficacious mental and physical vigor. Each item is rated on a 5-point Likert-type scale ranging from 1 ("completely false") to 5 ("completely true"); the total John Henryism scores range from 12 to 60, with higher scores indicating a greater inclination to cope with perceived stressors actively, rather than passively ($\alpha = .86$).

Presence of chronic illness(es). Respondents self-reported whether or not a doctor or nurse they visited told them that they had any of the following common chronic illnesses: Osteoarthritis, Gout, Lupus, Fibromyalgia, Osteoporosis, Arthritis, Diabetes, Ulcer, Psoriasis, Pain, Glaucoma, Stroke, Cholesterol, Heart disease, Asthma, Lung, Liver, Hypertension, Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Depression, Anxiety, HIV, Cancer, and other chronic illnesses. Response choices were coded as either no (0) or yes (1). Respondents were instructed to check all the illnesses that may apply.

Demographic characteristics. Four demographic variables were included in the analyses: race, age, marital status, and education. Although the study was designed only to include Black males, participants were asked to self-identify their race group (Black/African American, White, Hispanic, Asian). It is our assumption that the participants who self-identify as Black males are from various cultural backgrounds such as Jamaican, Haitian, African, and Black (referring specifically to Black Americans). Those who did not self-identify as Black/African American were excluded from study participation. Age was included as a continuous variable. Education was entered as a dichotomous variable (<12 years; ≥ 12 or more years of education).

Data Analytic Strategy

We calculated descriptive analyses to measure and gather a general profile of the sample's demographic (age, education, marital status), social (ethnic identity, self-esteem), and psychological (active coping) characteristics. Using pairwise deletion, we conducted a series of bivariate correlations to determine a parsimonious model ($p < .05$) and to determine the strength of the associations between general well-being and each study covariate. A hierarchical regression analysis was further specified to determine the amount of unique variance in general well-being accounted for by the demographic variables, social variables, and psychological variable. For the regression procedure, we entered the predictor variables into three models. Demographic variables (marital status, education) were entered first (Model I), followed by ethnic identity and self-esteem (Model II). The remaining psychological variables (active coping) were entered as the final set of predictor variables (Model III). Standardized beta coefficients were reported

Table 1. Demographic and Social Characteristics (N = 145).

Variable	M ± SD/%
Age	42.1 ± 6.2
Education (More than 12 years)	95%
Marital status (% married)	58%
Have a primary care physician (%Yes)	68%
Current chronic illness diagnoses	
Diabetes	67%
Hypertension	59%
Psoriasis	31%
Osteoporosis	29%
Pain	26%
Arthritis	18%
Cancer	14%
Ulcer	12%
Asthma	6%
Gout	6%
Depression	5%
Fibromyalgia	1%
Glaucoma	1%
Heart disease	.7%

to describe the relative importance of the predictor variables within the regression model. We determined statistical significance with the probability of a Type I error, $p \leq .05$. All statistical analyses were conducted using SPSS version 23.0 (SPSS Inc., Chicago, IL).

Results

Sample Characteristics

Participants were 145 self-identified Black men, with a mean age of 42.12 ($SD = 6.16$) years. The majority of the sample (95%) reported having more than 12 years of education. In total, 58% of the participants reported being married. Of the total sample, 68% reported having a primary care/family physician. The most commonly reported chronic illnesses were diabetes (66.9%), followed by hypertension (59.3%), osteoporosis (29.0%), pain (25.5%), and arthritis (17.9%). Other demographic, health, and social characteristics are provided in Table 1.

Associations of General Well-Being With Study Covariates

Results showed a significant positive association between general well-being and age ($r = .20, p < .02$) and self-esteem ($r = .24, p < .01$) (see Table 2). As the age of the Black males increases, so does the tendency to report positive well-being. Black males with a higher positive attitude toward self-worth reported higher positive well-being. A significant negative association was found between general well-being and marital status ($r = -.17, p < .05$), suggesting that those who are single reported less positive well-being. Also, general

Table 2. Association Between General Well-Being and Study Covariates.

Variable	r
Age	.20*
Marital status	-.17*
Education	-.04
Ethnic identity	-.34**
Self-esteem	.24**
Active coping	-.34*

Note. Pearson's Product-Moment.
* $p < .05$. ** $p < .01$.

well-being was negatively correlated with ethnic identity ($r = .34, p = .00$). Data similarly showed a significant moderate association between general well-being and active coping, with active coping being associated with negative perceptions of general well-being ($r = -.38, p = .00$). Education was the only covariate not significantly associated with general well-being ($r = -.04, p = .67$).

Multivariate Analysis

We conducted a hierarchical multiple regression model to determine the amount of unique variance in general well-being accounted for by demographic, social, and psychological variables (Table 3). The first step in model development involved entering the demographic variables (education, marital status; Model I). These variables accounted for 3% of the total general well-being. However, only marital status ($\beta = -.16, p < .05$) was a significant indicator of general well-being. Next, we entered ethnic identity ($\beta = -.35, p < .01$) and self-esteem ($\beta = .24, p < .01$) in Model II, which accounted for 19% of the total variance. When entered into Model II, marital status was not retained as a significant indicator of general well-being ($\beta = -.07, p = .38$). Table 3 shows that after controlling for the demographic characteristics and social variables, the psychological variable (active coping; Model III) accounted for another 20% of the model's variance. Only the effect of self-esteem remained significant when the social indicators were included in the analyses.

The full regression model was significant, $F(5,138) = 7.02, p < .001$. When the three models were included in the final analysis, self-esteem was a significant indicator of general well-being among Black males ($\beta = .22, p < .001$). Active coping had a marginal significance with general well-being among Black males ($\beta = -.41, p = .09$).

Discussion

The present study aimed to investigate the impact of ethnic identity, self-esteem, and active coping on the general well-being of older Black males with chronic illness. While there is an increased interest documenting the needs of Black males, there remains a dearth of

Table 3. Predictors of General Well-Being Among Black Males With Chronic Illness.

Variable	Model		
	Model 1	Model 2	Model 3
Demographic			
Marital status	-.17*	-.07	-.07
Education	-.35	.05	.05
R ²			.03
Adjusted R ²			.02
R ² change			.03
p value			NS
Social			
Ethnic identity		-.35*	.04
Self-esteem		.24*	.22*
R ²			.19
Adjusted R ²			.16
R ² change			.16
p value			<.001
Psychological			
Active coping			-.41**
R ²			.20
Adjusted R ²			.17
R ² change			.01
p value			<.001

Note. Hierarchical regression; NS = non significant.

*p < .01. **p < .09.

information acknowledging the association of these variables to men's health. Our data shows that Black males with greater attachment to their ethnic identity reported more positive general well-being. Strong ethnic identity creates a sense of belonging to a group, which has positive effects on an individual's well-being (Haslam et al., 2009). Our data suggest a positive relationship between a shared sense of racial identity and an enhanced ability to cope with the stressors of chronic illness. This finding goes along with previous research, which suggests that a strong sense of identification positively impacts self-evaluation and self-worth (Haslam et al., 2009). Higher identification with one's ethnic group has been linked to higher levels of self-esteem in Black males (e.g., Phinney & Chavira, 1992), and higher levels of self-esteem are associated to individual well-being and mental health (e.g., Mahalik, Pierre, & Wan, 2006; Munford, 1994).

Data show that Black males with more positive views of self-worth were more likely to report a more positive general well-being, suggesting that self-esteem can be a contributing factor in the well-being of older Black males with chronic illness. In addition to the relationship between ethnic identity and self-esteem several factors may partly explain this finding; for instance, self-esteem has been found to positively correlate with social engagement (Leary, Tambor, Terdal, & Downs, 1995). It may be that Black males with high self-esteem are more likely to be immersed in social interactions, meaning

that they spend less time being limited by the experience of chronic illness. Similarly, interpersonal engagement may distract from the negative experience of chronic illness (i.e., functional difficulties and loss of mobility) which would, in turn, result in a more positive perception of quality of life and general well-being (Juth, Smyth, & Santuzzi, 2008).

In addition, research suggests that low self-esteem is associated with reports of more prevalent and debilitating symptoms, and symptom severity relates to a diminished quality of life (Juth et al., 2008). Exhausted by the presence of their negative symptoms, Black males with low self-esteem may avoid protective factors (e.g., social support, engagement in pleasurable activities) that are important for maintenance of well-being or lead to positive health outcomes. To that end, it is implied that self-esteem can be an important coping resource which may have main and moderator effects on the well-being of Black males.

Our data also reveal a positive relationship between marital status and well-being. Although we are limited by the correlational nature of this data, it is possible that marriage acts as a protective factor for some Black males. This finding is consistent with existing literature investigating the relationship of marriage and well-being. Social support has been shown to be a protective factor against the development of psychiatric disorders (e.g., depression and anxiety) and may have ameliorative effects on health conditions (Broadhead et al., 1983; Soulsby & Bennett, 2015; Wang, Wu, & Liu, 2003). Moreover, literature extensively notes the positive benefits of marriage on well-being (Coombs, 1991; Diener, Gohm, Suh, & Oishi, 2000; Haring-Hidore, Stock, Okun, & Witter, 1985; Wood, Rhodes, & Whelan, 1989). Married individuals experience less emotional and physical health problems, and these rewards appear to be more pronounced for men than for women (Coombs, 1991; Haring-Hidore et al., 1985). Social support has been identified as a mechanism through which this effect occurs (Barrett, 1999; Hewitt, Turrel, & Giske., 2010; Soulsby & Bennett, 2015). This indicates that single Black males who reported less positive well-being may be denied the benefits of the type of social support obtained through a secure social relationship such as marriage. Furthermore, because women are far more likely to monitor their health and engage in healthy practices (Courtenay, 2000), Black males in secure relationships with women can enjoy the benefits of their spouses' healthy behaviors. Hence, it may be worthwhile for intervention programs targeting this group to identify ways in which *single* Black males can achieve this type of social support.

Furthermore, results suggested that Black males who reported a greater inclination to actively cope with perceived stressors were more likely to hold negative perceptions of their general well-being. This finding is contrary to some existing research investigating the relationship between active coping and perceptions of general well-being. While some studies suggest that

there is an association between active coping strategies and self-rated well-being (Bonham, Sellers, & Neighbors, 2004; Haritatos, Mahalingam, & James, 2007; Lo, 2002; Samuel-Hodge, Watkins, Rowell, & Hooten, 2008), others indicate that when coupled with social and economic constraints (e.g., low socioeconomic status, low educational attainment, perceived racism), active coping can result in negative perceptions of well-being and adverse health outcomes (Dressler, Bindon, & Neggers, 1998; James et al., 1987). The present study suggests that for Black males, the use of active coping is associated with a negative perception of general well-being. Hence, it is possible that as their experience of health becomes poorer, Black males may turn to active coping strategies. This predisposition may increase when burdened with socioeconomic constraints. Further research is warranted to illuminate the association between active coping and negative perceptions of well-being, and implications for health outcomes for this specific population.

Although this study demonstrated unique associations between general well-being and psychosocial factors among older Black males with chronic illness, some limitations must be acknowledged. First, this was a cross-sectional study; therefore, changes over time or established causal associations in reported well-being could not be determined. Another limitation was the higher number of younger Black males within the sample. The majority of the sample were men below the age of 50. Although identifying the trajectories of important health indicators is central to forecasting health needs and generating interventions for older persons, our ability to generalize these findings to older males is limited.

Furthermore, our criterion for study participation was not limited to a specific chronic illness. Therefore, we cannot definitively compare our findings with other studies examining general well-being in Black males with specific chronic illness. Finally, the data were collected via self-reports, which may result in potential reporting bias such as social desirability. In our sample, social desirability may have yielded responses that were favorable to that of the males. Despite these limitations, our finding makes a significant contribution to the literature as it explores the impact of chronic illness on the general well-being and optimal functioning of Black males.

Conclusion

To summarize, our study demonstrated that among Black males with chronic illness, high self-esteem, marriage, and an attachment to one's ethnic identity were all associated with positive general well-being. Engagement in active coping was related to a negative perception of general well-being. These findings hold important implications of for the health care of chronically ill Black males. Seemingly, Black males burdened with chronic illness may benefit from interventions that emphasize

self-esteem, secure social relationships and strong ethnic identity in promoting general well-being. It could be worthwhile for health care providers and practitioners to educate Black males with chronic illnesses of the importance of social support as an effective coping mechanism. Integrating this form of coping into treatment plans may result in positive health outcomes.

In addition, health intervention programs (e.g., chronic disease self-management programs (CDSMPs)) need to educate individuals about the emotional and physical health benefits of secure social relationships. A focus should also be placed on the individual's identification with their ethnic group, as ethnic identity has been linked to positive well-being. Therefore, health care providers and practitioners must be cognizant of the unique ethnic identities of this population and if need be, modify their practice to address their specific needs.



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References

- Aldwin, C. M., Igarashi, H., Gilmer, D. F., & Levenson, M. R. (2017). *Health, illness, and optimal aging: Biological and psychosocial perspectives*. New York, NY: Springer Publishing Company.
- Aspinwall, L. G., & Taylor, S. E. (1997). A stitch in time: Self-regulation and proactive coping. *Psychological Bulletin*, 121, 417-436.
- Atakere, D., & Baker, T. (2016). Immuned by race: Ethnic identity, masculinity, and attachment as predictors of cancer screening among Black men. *Psychology*, 7, 1023-1033. doi:10.4236/psych.2016.77103
- Baker, T. A., Clay, O. J., Johnson-Lawrence, V., Minahan, J. A., Mingo, C. A., Thorpe, R. J., . . . Crowe, M. (2017). Association of multiple chronic conditions and pain among older Black and White adults with diabetes mellitus. *BMC Geriatrics*, 17(1), Article 255.
- Barrett, A. E. (1999). Social support and life satisfaction among the never married: Examining the effects of age. *Research on Aging*, 21(1), 46-72.

- Beard, J. R., Officer, A., de Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J. P., . . . Thyagarajan, J. A. (2016). The World report on ageing and health: A policy framework for healthy ageing. *The Lancet*, 387, 2145-2154.
- Bonham, V. L., Sellers, S. L., & Neighbors, H. W. (2004). John Henryism and self-reported physical health among high-socioeconomic status African American men. *American Journal of Public Health*, 94, 737-738.
- Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*, 77, 135-149.
- Broadhead, W. E., Kaplan, B. H., James, S. A., Wagner, E. H., Schoenbach, V. J., Grimson, R., . . . Gehlbach, S. H. (1983). The epidemiologic evidence for a relationship between social support and health. *American Journal of Epidemiology*, 117, 521-537.
- Bronder, E. C., Speight, S. L., Witherspoon, K. M., & Thomas, A. J. (2014). John Henryism, depression, and perceived social support in Black women. *Journal of Black Psychology*, 40, 115-137.
- Center for Disease Control and Prevention. (2016). *Summary health statistics: National health interview survey, 2016*. Retrieved from <https://www.cdc.gov/nchs/nhis/shs.htm>
- Coombs, R. H. (1991). Marital status and personal well-being: A literature review. *Family Relations*, 40, 97-102.
- Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50, 1385-1401.
- Diener, E., Gohm, C. L., Suh, E., & Oishi, S. (2000). Similarity of the relations between marital status and subjective well-being across cultures. *Journal of Cross-Cultural Psychology*, 31, 419-436.
- Dressler, W. W., Bindon, J. R., & Neggers, Y. H. (1998). John Henryism, gender, and arterial blood pressure in an African American community. *Psychosomatic Medicine*, 60, 620-624.
- Dupuy, H. J. (1984). The psychological general well-being (PGWB) index. *Assessment of quality of life in clinical trials of cardiovascular therapies*, 170-183.
- Folkman, S. (1984). Personal control and stress and coping processes: A theoretical analysis. *Journal of Personality and Social Psychology*, 46, 839-852.
- Goodstein, R., & Ponterotto, J. G. (1997). Racial and ethnic identity: Their relationship and their contribution to self-esteem. *Journal of Black Psychology*, 23, 275-292.
- Harburg, E., Erfurt, J. C., Chape, C., Hauenstein, L. S., Schull, W. J., & Schork, M. A. (1973). Socioecological stressor areas and black-white blood pressure: Detroit. *Journal of Chronic Diseases*, 26(9), 595-611.
- Haring-Hidore, M., Stock, W. A., Okun, M. A., & Witter, R. A. (1985). Marital status and subjective well-being: A research synthesis. *Journal of Marriage and the Family*, 47, 947-953.
- Haritatos, J., Mahalingam, R., & James, S. A. (2007). John Henryism, self-reported physical health indicators, and the mediating role of perceived stress among high socioeconomic status Asian immigrants. *Social Science & Medicine*, 64, 1192-1203.
- Haslam, S. A., Jetten, J., Postmes, T., & Haslam, C. (2009). Social identity, health and well-being: An emerging agenda for applied psychology. *Applied Psychology: An International Review*, 58(1), 1-23.
- Haslam, S. A., O'Brien, A., Jetten, J., Vormedal, K., & Penna, S. (2005). Taking the strain: Social identity, social support, and the experience of stress. *British Journal of Social Psychology*, 44, 355-370.
- Hewitt, B., Turrell, G., & Giskes, K. (2010). Marital Loss, Mental Health and the Role of Perceived Social Support: Findings from Six Waves of an Australian Population Panel Study. *Journal of Epidemiology & Community Health*, 66, 308-314. doi:10.1136/jech.2009.104893
- James, S. A. (1994). John Henryism and the health of African-Americans. *Culture, medicine and psychiatry*, 18(2), 163-182.
- James, S. A., LaCroix, A. Z., Kleinaum, D. G., & Strogatz, D. S. (1984). John Henryism and blood pressure differences among Black men. II. The role of occupational stressors. *Journal of Behavioral Medicine*, 7, 259-275.
- James, S. A., Strogatz, D. S., Wing, S. B., & Ramsey, D. L. (1987). Socioeconomic status, John Henryism, and hypertension in Blacks and Whites. *American Journal of Epidemiology*, 126, 664-673.
- Juth, V., Smyth, J. M., & Santuzzi, A. M. (2008). How do you feel? Self-esteem predicts affect, stress, social interaction, and symptom severity during daily life in patients with chronic illness. *Journal of Health Psychology*, 13, 884-894.
- Leary, M. R., Tambor, E. S., Terdal, S. K., & Downs, D. L. (1995). Self-esteem as an interpersonal monitor: The sociometer hypothesis. *Journal of Personality and Social Psychology*, 68, 518-530.
- Leung, M. Y. M., Pollack, L. M., Colditz, G. A., & Chang, S. H. (2015). Life years lost and lifetime health care expenditures associated with diabetes in the US, National health interview survey, 1997-2000. *Diabetes Care*, 38, 460-468.
- Lo, R. (2002). A longitudinal study of perceived level of stress, coping and self-esteem of undergraduate nursing students: An Australian case study. *Journal of Advanced Nursing*, 39, 119-126.
- Mahalik, J. R., Pierre, M. R., & Wan, S. S. (2006). Examining racial identity and masculinity as correlates of self-esteem and psychological distress in Black men. *Journal of Multicultural Counseling and Development*, 34, 94-104.
- Martinez, R. O., & Dukes, R. L. (1997). The effects of ethnic identity, ethnicity, and gender on adolescent well-being. *Journal of Youth and Adolescence*, 26, 503-516.
- Munford, M. B. (1994). Relationship of gender, self-esteem, social class, and racial identity to depression in Blacks. *Journal of Black Psychology*, 20, 157-174.
- Jenkins, J. H. (2016). *Extraordinary conditions: Culture and experience in mental illness*. Oakland: University of California Press. (Original work published 2015)
- Phinney, J. S. (1992). The multigroup ethnic identity measure: A new scale for use with diverse groups. *Journal of Adolescent Research*, 7, 156-176.
- Phinney, J. S., & Chavira, V. (1992). Ethnic identity and self-esteem: An exploratory longitudinal study. *Journal of Adolescence*, 15, 271-281.
- Phinney, J. S., & Ong, A. D. (2007). Conceptualization and measurement of ethnic identity: Current status and future directions. *Journal of Counseling Psychology*, 54, 271-281.
- Pollard, K., & Scommegna, P. (2013). The health and life expectancy of older Blacks and Hispanics in the United States. *Population Reference Bureau*, 28, 1-8.

- Rosenberg, M. (1965). *Rosenberg self-esteem scale (RSE)*. *Acceptance and commitment therapy: Measures package*, 61, 52.
- Samuel-Hodge, C. D., Watkins, D. C., Rowell, K. L., & Hooten, E. G. (2008). Coping styles, well-being, and self-care behaviors among African Americans with type 2 diabetes. *The Diabetes Educator*, 34, 501-510.
- Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology*, 84, 1079-1092.
- Siegel, R. L., Miller, K. D., & Jemal, A. (2016). Cancer statistics, 2016. *CA: A Cancer Journal for Clinicians*, 66, 7-30.
- Soulsby, L. K., & Bennett, K. M. (2015). Marriage and psychological wellbeing: The role of social support. *Psychology*, 6, 1349-1359.
- Tajfel, H. (1972). Social categorization, English manuscript of La catégorization sociale. *Introduction à la psychologie sociale*, 1.
- Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 7-24). Chicago, IL: Nelson-Hall.
- Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *American psychologist*, 55, 99-109.
- Wang, H. H., Wu, S. Z., & Liu, Y. Y. (2003). Association between social support and health outcomes: A meta-analysis. *The Kaohsiung Journal of Medical Sciences*, 19, 345-350.
- Wegge, J., Van Dick, R., Fisher, G. K., Wecking, C., & Moltzen, K. (2006). Work motivation, organisational identification, and well-being in call centre work. *Work & Stress*, 20, 60-83.
- Weir, H. K., Thompson, T. D., Soman, A., Møller, B., & Leadbetter, S. (2015). The past, present, and future of cancer incidence in the United States: 1975 through 2020. *Cancer*, 121, 1827-1837.
- Williams, B. (1983). *John Henry, a bio-bibliography*. Santa Barbara, CA: Greenwood.
- Wood, W., Rhodes, N., & Whelan, M. (1989). Sex differences in positive well-being: A consideration of emotional style and marital status. *Psychological Bulletin*, 106, 249-264.
- Zack, M. M. (2013). Health-related quality of life—United States, 2006 and 2010. *Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, CDC*, 62, 105-111.